106TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. BLILEY (for himself, Mr. DINGELL, Mr. BILIRAKIS, Mr. BROWN of Ohio, [insert names of additional cosponsors from attached list]) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to make additional corrections and refinements in the Medicare, Medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO OTHER ACTS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Beneficiary Improvement and Protection Act of 2000''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amend-

ment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO OTHER ACTS.—In this Act:

(1) BALANCED BUDGET ACT OF 1997.—The term ''BBA'' means the Balanced Budget Act of 1997 (Public Law 105–33).

(2) MEDICARE, MEDICAID, AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 1999.—The term ''BBRA'' means the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted into law by section 1000(a)(6) of Public Law 106–113 (Appendix F).

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—BENEFICIARY IMPROVEMENTS

SEC. 101. ELIMINATION OF TIME LIMITATION ON MEDICARE BENEFITS FOR IMMUNOSUPPRESSIVE DRUGS.

(a) IN GENERAL.—Section 1861(s)(2)(J) (42 U.S.C. 1395x(s)(2)(J)) is amended by striking ", but only" and all that follows up to the semicolon at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs furnished on or after the date of the enactment of this Act.

SEC. 102. PRESERVATION OF COVERAGE OF DRUGS AND BIOLOGICALS UNDER PART B OF THE MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking "(including drugs and biologicals which cannot,

as determined in accordance with regulations, be self-administered)'' and inserting ''(including drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

SEC. 103. STUDY ON LIMITATION ON STATE PAYMENT FOR MEDICARE COST-SHARING AFFECTING ACCESS TO SERVICES FOR QUALIFIED MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine if access to certain services (including mental health services) for qualified medicare beneficiaries has been affected by limitations on a State's payment for medicare cost-sharing for such beneficiaries under section 1902(n) of the Social Security Act (42 U.S.C. 1396a(n)). As part of such study, the Secretary shall analyze the effect of such payment limitation on providers who serve a disproportionate share of such beneficiaries.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act the Secretary shall submit to Congress a report on the study under subsection (a). The report shall include recommendations regarding any changes that should be made to the State payment limits under section 1902(n) for qualified medicare beneficiaries to ensure appropriate access to services.

SEC. 104. WAIVER OF 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE OF INDIVIDUALS DISABLED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS).

(a) IN GENERAL.—Section 226 (42 U.S.C. 426) is amended—

(1) by redesignating subsection (h) as subsection (j) and by moving such subsection to the end of the section, and

(2) by inserting after subsection (g) the following new subsection:

''(h) For purposes of applying this section in the case of an individual medically determined to have amyotrophic lateral sclerosis (ALS), the following special rules apply:

''(1) Subsection (b) shall be applied as if there were no requirement for any entitlement to benefits, or status, for a period longer than 1 month.

''(2) The entitlement under such subsection shall begin with the first month (rather than twenty-fifth month) of entitlement or status.

''(3) Subsection (f) shall not be applied.''.

(b) CONFORMING AMENDMENT.—Section 1837 (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(j) In applying this section in the case of an individual who is entitled to benefits under part A pursuant to the operation of section 226(h), the following special rules apply:

''(1) The initial enrollment period under subsection (d) shall begin on the first day of the first month in which the individual satisfies the requirement of section 1836(1).

''(2) In applying subsection (g)(1), the initial enrollment period shall begin on the first day of the first month of entitlement to disability insurance benefits referred to in such subsection.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to benefits for months beginning after the date of the enactment of this Act.

TITLE II—OTHER MEDICARE PART B PROVISIONS

SEC. 201. 3-YEAR MORATORIUM ON SNF PART B CONSOLIDATED BILLING REQUIREMENTS.

(a) MORATORIUM IN APPLICATION OF CONSOLIDATED BILLING TO SNF RESIDENTS IN NON-COVERED STAYS.—Section 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by inserting ''(on or after October 1, 2003)'' after ''furnished to an individual''.

(b) MORATORIUM IN PROVIDER AGREEMENT PROVISION.—Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.

1395cc(a)(1)(H)(ii)(I) is amended by inserting ''in the case of a resident who is in a stay covered under part A, and for services furnished on or after October 1, 2003, in the case of a resident who is not in a stay covered under such part'' before the comma.

(c) MORATORIUM IN REQUIREMENT FOR SNF BILLING OF PART B SERVICES.—Section 1862(a)(18) (42 U.S.C. 1395y(a)(18)) is amended to read as follows:

''(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident—

''(A) of a skilled nursing facility in the case of a resident who is in a stay covered under part A; or

''(B) of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations) for services furnished on or after October 1, 2003, in the case of a resident who is not in a stay covered under such part,

by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility;''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b) and (c) are effective as if included in the enactment of BBA.

(e) REPORT.—Not later than October 1, 2002, the Comptroller General of the United States shall submit to Congress a report that includes an analysis and recommendations on—

(1) alternatives, if any, to consolidated billing for part B items and services described in section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6)) to ensure accountability by skilled nursing facilities and accuracy in claims submitted for all services and items provided to skilled nursing facility residents under part B of the medicare program;

(2) the costs expected to be incurred by skilled nursing facilities under such alternative approaches, compared with

the costs associated with the implementation of consolidated billing; and

(3) the costs incurred by the medicare program in implementing such alternative approaches and their effect on utilization review, compared with the costs and effect on utilization review expected with consolidated billing.

SEC. 202. GAO STUDY OF SITE-OF-SERVICE DIFFERENTIAL FOR GASTROINTESTINAL ENDOSCOPIC SERVICES FURNISHED IN PHYSICIANS OFFICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the appropriateness of furnishing gastrointestinal endoscopic physicians services in physicians offices. In conducting this study, the Comptroller General shall—

(1) review available scientific and clinical evidence about the safety of performing procedures in physicians offices and hospital outpatient departments;

(2) assess whether resource-based practice expense relative values established by the Secretary of Health and Human Services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for gastrointestinal endoscopic services furnished in physicians offices and hospital outpatient departments create an incentive to furnish such services in physicians offices instead of hospital outpatient departments; and

(3) assess the implications for access to care for Medicare beneficiaries if Medicare were not to cover gastrointestinal endoscopic services in physicians offices.

(b) REPORT.—The Comptroller General shall submit a report to Congress on such study no later than July 1, 2002 and include such recommendations as the Comptroller General determines to be appropriate.

SEC. 203. 1-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.

(a) IN GENERAL.—Section 1833(g)(4) (42 U.S.C. 1395l(g)), as added by section 221(a) of BBRA, is amended by striking ''and 2001'' and inserting '', 2001, and 2002''.

(b) CONFORMING AMENDMENT TO CONTINUE FOCUSED MEDICAL REVIEWS OF CLAIMS DURING MORATORIUM PERIOD.—Section 221(a)(2) of BBRA is amended by striking ''(under the amendment made by paragraph (1)(B))''.

SEC. 204. REVISION OF MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.

Section 4206 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l note) is amended to read as follows:

''(a) TELEHEALTH SERVICES REIMBURSED.—

''(1) IN GENERAL.—Not later than January 1, 2001, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund in accordance with the methodology described in subsection (b) for services for which payment may be made under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that are furnished via a telecommunications system by a physician or practitioner to an eligible telehealth beneficiary.

''(2) USE OF STORE-AND-FORWARD TECHNOLOGIES.—For purposes of paragraph (1), in the case of any Federal telemedicine demonstration program in Alaska or Hawaii, the term 'telecommunications system' includes store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.

''(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—The Secretary shall make payment under this section as follows:

''(A) Subject to subparagraph (B), with respect to a physician or practitioner located at a distant site that furnishes a service to an eligible medicare beneficiary under subsection (a), an amount equal to the amount that such physician or practitioner would have been paid had the service been furnished without the use of a telecommunications system.

"(B) With respect to an originating site, a facility fee equal to—

"(i) for 2000 and 2001, $20; and

"(ii) for a subsequent year, the facility fee under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year.

"(2) APPLICATION OF PART B COINSURANCE AND DEDUCTIBLE.—Any payment made under this section shall be subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

"(c) TELEPRESENTER NOT REQUIRED.—Nothing in this section shall be construed as requiring an eligible telehealth beneficiary to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system.

"(d) COVERAGE OF ADDITIONAL SERVICES.—

"(1) STUDY AND REPORT ON ADDITIONAL SERVICES.—

"(A) STUDY.—The Secretary of Health and Human Services shall conduct a study to identify services in addition to those described in subsection (a)(1) that are appropriate for payment under this section.

"(B) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subparagraph (A) together with such recommendations for legislation that the Secretary determines are appropriate.

"(2) IN GENERAL.—The Secretary shall provide for payment under this section for services identified in paragraph (1).

"(e) CONSTRUCTION RELATING TO HOME HEALTH SERVICES.—

"(1) IN GENERAL.—Nothing in this section or in section 1895 of the Social Security Act (42 U.S.C. 1395fff) shall be construed as preventing a home health agency furnishing a home health unit of service for which payment is made under the prospective payment system established in such section for such units of service from furnishing the service.

"(2) LIMITATION.—The Secretary shall not consider a home health service provided in the manner described in paragraph (1) to be a home health visit for purposes of—

"(A) determining the amount of payment to be made under such prospective payment system; or

"(B) any requirement relating to the certification of a physician required under section 1814(a)(2)(C) of such Act (42 U.S.C. 1395f(a)(2)(C)).

"(f) DEFINITIONS.—In this section:

"(1) ELIGIBLE TELEHEALTH BENEFICIARY.—The term 'eligible telehealth beneficiary' means an individual enrolled under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) that resides in—

"(A) an area that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A));

"(B) a county that is not included in a Metropolitan Statistical Area;

"(C) an inner-city area that is medically underserved (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))); or

"(D) an area in which a Federal telemedicine demonstration program is carried out.

"(2) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r))

"(3) PRACTITIONER.—The term 'practitioner' means a practitioner described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)).

"(4) DISTANT SITE.—The term 'distant site' means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.

"(5) ORIGINATING SITE.—

"(A) IN GENERAL.—The term 'originating site' means any site described in subparagraph (B) at which the eligible telehealth beneficiary is located at the time the service is furnished via a telecommunications system.

"(B) SITES DESCRIBED.—The sites described in this subparagraph are as follows:

"(i) On or after January 1, 2001—

"(I) the office of a physician or a practitioner,

"(II) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act (42 U.S.C. 1395x(mm)(1))),

"(III) a rural health clinic (as defined in section 1861(aa)(2) of such Act (42 U.S.C. 1395x(aa)(2))), and

"(IV) a Federally qualified health center (as defined in section 1861(aa)(4) of such Act (42 U.S.C. 1395x(aa)(4))).

"(ii) On or after October 1, 2001—

"(I) a hospital (as defined in section 1861(e) of such Act (42 U.S.C. 1395x(e))),

"(II) a skilled nursing facility (as defined in section 1861(j) of such Act (42 U.S.C. 1395x(j))),

"(III) a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2) of such Act (42 U.S.C. 1395x(cc)(2))),

"(IV) a renal dialysis facility (described in section 1881(b)(1) of such Act (42 U.S.C. 1395rr(b)(1))),

"(V) an ambulatory surgical center (described in section 1833(i)(1)(A) of such Act (42 U.S.C. 1395l(i)(1)(A))),

"(VI) a hospital or skilled nursing facility of the Indian Health Service (under section 1880 of such Act (42 U.S.C. 1395qq)), and

"(VII) a community mental health center (as defined in section 1861(ff)(3)(B) of such Act (42 U.S.C. 1395x(ff)(3)(B))).

"(6) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—The term 'Federal Supplementary Medical Insurance Trust Fund' means the trust fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t).".

SEC. 205. CONTRAST ENHANCED DIAGNOSTIC PROCEDURES UNDER HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) SEPARATE CLASSIFICATION.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(1) by striking "and" at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(3) by inserting after subparagraph (F) the following new subparagraph:

"(G) the Secretary shall create additional groups of covered OPD services that classify separately those procedure2 that utilize contrast media from those that do not.".

(b) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of BBA.

SEC. 206. STATE ACCREDITATION OF DIABETES SELF-MANAGEMENT TRAINING PROGRAMS.

Section 1861(qq)(2) (42 U.S.C. 1395xx(qq)(2)) is amended—

(1) in the matter preceding subparagraph (A) by striking "paragraph (1)—" and inserting "paragraph (1):";

(2) in subparagraph (A)—

(A) by striking ''a 'certified provider' '' and inserting ''A 'certified provider' ''; and

(B) by striking ''; and'' and inserting a period; and

(3) in subparagraph (B)—

(A) by striking ''a physician, or such other individual'' and inserting ''(i) A physician, or such other individual'';

(B) by inserting ''(I)'' before ''meets applicable standards'';

(C) by inserting ''(II)'' before ''is recognized'';

(D) by inserting '', or by a program described in clause (ii),'' after ''recognized by an organization that represents individuals (including individuals under this title) with diabetes''; and

(E) by adding at the end the following:

''(ii) Notwithstanding any reference to 'a national accreditation body' in section 1865(b), for purposes of clause (i), a program described in this clause is a program operated by a State for the purposes of accrediting diabetes self-management training programs, if the Secretary determines that such State program has established quality standards that meet or exceed the standards established by the Secretary under clause (i) or the standards originally established by the National Diabetes Advisory Board and subsequently revised as described in clause (i).''.

SEC. 207. DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES.

Title XVIII is amended by inserting after section 1866 the following new sections:

''DEMONSTRATION OF APPLICATION OF PHYSICIAN VOLUME INCREASES TO GROUP PRACTICES

''SEC. 1866A. (a) DEMONSTRATION PROGRAM AUTHORIZED.—

"(1) IN GENERAL.—The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this title that—

"(A) encourage coordination of the care furnished to individuals under the programs under parts A and B by institutional and other providers, practitioners, and suppliers of health care items and services;

"(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

"(C) reward physicians for improving health outcomes.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866B.

"(3) DEFINITIONS.—For purposes of this section, terms have the following meanings:

"(A) PHYSICIAN.—Except as the Secretary may otherwise provide, the term 'physician' means any individual who furnishes services which may be paid for as physicians' services under this title .

"(B) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physicians' services under this title. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

"(b) ELIGIBILITY CRITERIA.—

"(1) IN GENERAL.—The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

"(2) PAYMENT METHOD.—A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

"(A) to be paid on a fee-for-service basis; and

"(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate by the Secretary) be made to a single entity.

"(3) DATA REPORTING.—A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary require, for purposes of monitoring and evaluation of the demonstration under this section.

"(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

"(1) IN GENERAL.—The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

"(2) OTHER CRITERIA.—The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include frequency of contact with physicians in the group or other factors or criteria that the Secretary finds to be appropriate.

"(3) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to be within the scope of a demonstration under this section with respect to a specific

health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

"(d) INCENTIVES.—

"(1) PERFORMANCE TARGET.—The Secretary shall establish for each health care group participating in a demonstration under this section—

"(A) a base expenditure amount, equal to the average total payments under parts A and B for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

"(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

"(2) INCENTIVE BONUS.—The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the Medicare savings realized for such year relative to the performance target.

"(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—At such time as the Secretary has established appropriate criteria based on evidence the Secretary determines to be sufficient, the Secretary shall also pay to a participating health care group (subject to paragraph (4)) an additional bonus for a year, equal to such portion as the Secretary may designate of the saving to the program under this title resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

"(4) LIMITATION.—The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Sec-

retary estimates would be expended if the demonstration projects under this section were not implemented.

''PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

''SEC. 1866B. (a) GENERAL ADMINISTRATIVE AUTHORITY.—

''(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1866A (in this section referred to as the 'demonstration program') if such individual—

''(A) is enrolled in under the program under part B and entitled to benefits under part A; and

''(B) is not enrolled in a Medicare+Choice plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an organization with an agreement under section 1833(a)(1)(A), or a PACE program under section 1894.

''(2) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary may limit the implementation of the demonstration program to—

''(A) a geographic area (or areas) that the Secretary designates for purposes of the program, based upon such criteria as the Secretary finds appropriate;

''(B) a subgroup (or subgroups) of beneficiaries or individuals and entities furnishing items or services (otherwise eligible to participate in the program), selected on the basis of the number of such participants that the Secretary finds consistent with the effective and efficient implementation of the program;

''(C) an element (or elements) of the program that the Secretary determines to be suitable for implementation; or

''(D) any combination of any of the limits described in subparagraphs (A) through (C).

"(3) VOLUNTARY RECEIPT OF ITEMS AND SERVICES.—Items and services shall be furnished to an individual under the demonstration program only at the individual's election.

"(4) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to beneficiaries under the demonstration program.

"(5) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the demonstration program including, as applicable, standards for quality of health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

"(6) ADMINISTRATIVE REVIEW OF DECISIONS AFFECTING INDIVIDUALS AND ENTITIES FURNISHING SERVICES.—An individual or entity furnishing services under the demonstration program shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into, or to terminate, or not to renew, an agreement with the entity to provide health care items or services under the program.

"(7) SECRETARY'S REVIEW OF MARKETING MATERIALS.—An agreement with an individual or entity furnishing services under the demonstration program shall require the individual or entity to guarantee that it will not distribute materials marketing items or services under the program without the Secretary's prior review and approval;

"(8) PAYMENT IN FULL.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), an individual or entity receiving payment from the Secretary under a contract or agreement

under the demonstration program shall agree to accept such payment as payment in full, and such payment shall be in lieu of any payments to which the individual or entity would otherwise be entitled under this title.

"(B) COLLECTION OF DEDUCTIBLES AND COINSURANCE.—Such individual or entity may collect any applicable deductible or coinsurance amount from a beneficiary.

"(b) CONTRACTS FOR PROGRAM ADMINISTRATION.—

"(1) IN GENERAL.—The Secretary may administer the demonstration program through a contract with a program administrator in accordance with the provisions of this subsection.

"(2) SCOPE OF PROGRAM ADMINISTRATOR CONTRACTS.—The Secretary may enter into such contracts for a limited geographic area, or on a regional or national basis.

"(3) ELIGIBLE CONTRACTORS.—The Secretary may contract for the administration of the program with—

"(A) an entity that, under a contract under section 1816 or 1842, determines the amount of and makes payments for health care items and services furnished under this title; or

"(B) any other entity with substantial experience in managing the type of program concerned.

"(4) CONTRACT AWARD, DURATION, AND RENEWAL.—

"(A) IN GENERAL.—A contract under this subsection shall be for an initial term of up to three years, renewable for additional terms of up to three years.

"(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (3)(A) without regard to the requirements of section 5 of title 41, United States Code.

"(5) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation shall apply to program administration contracts under this subsection.

"(6) PERFORMANCE STANDARDS.—The Secretary shall establish performance standards for the program administrator including, as applicable, standards for the quality and cost-effectiveness of the program administered, and such other factors as the Secretary finds appropriate. The eligibility of entities for the initial award, continuation, and renewal of program administration contracts shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

"(7) FUNCTIONS OF PROGRAM ADMINISTRATOR.—A program administrator shall perform any or all of the following functions, as specified by the Secretary:

"(A) AGREEMENTS WITH ENTITIES FURNISHING HEALTH CARE ITEMS AND SERVICES.—Determine the qualifications of entities seeking to enter or renew agreements to provide services under the program, and as appropriate enter or renew (or refuse to enter or renew) such agreements on behalf of the Secretary.

"(B) ESTABLISHMENT OF PAYMENT RATES.—Negotiate or otherwise establish, subject to the Secretary's approval, payment rates for covered health care items and services.

"(C) PAYMENT OF CLAIMS OR FEES.—Administer payments for health care items or services furnished under the program.

"(D) PAYMENT OF BONUSES.—Using such guidelines as the Secretary shall establish, and subject to the approval of the Secretary, make bonus payments as described in subsection (c)(2)(A)(ii) to entities furnishing items or services for which payment may be made under the program.

"(E) OVERSIGHT.—Monitor the compliance of individuals and entities with agreements under the program with the conditions of participation.

"(F) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subsection (a)(6).

"(G) REVIEW OF MARKETING MATERIALS.—Conduct a review of marketing materials proposed by an entity furnishing services under the program.

"(H) ADDITIONAL FUNCTIONS.—Perform such other functions as the Secretary may specify.

"(8) LIMITATION OF LIABILITY.—The provisions of section 1157(b) shall apply with respect to activities of contractors and their officers, employees, and agents under a contract under this subsection.

"(9) INFORMATION SHARING.—Notwithstanding section 1106 and section 552a of title 5, United States Code, the Secretary is authorized to disclose to an entity with a program administration contract under this subsection such information (including medical information) on individuals receiving health care items and services under the program as the entity may require to carry out its responsibilities under the contract.

"(c) RULES APPLICABLE TO BOTH PROGRAM AGREEMENTS AND PROGRAM ADMINISTRATION CONTRACTS.—

"(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to require entities with agreements to provide health care items or services under the demonstration program, and entities with program administration contracts under subsection (b), to maintain adequate records, to afford the Secretary access to such records (including for audit purposes), and to furnish such reports and other materials (including audited financial statements and performance data) as the Secretary may require for purposes of implementation, oversight, and evaluation of the program and of individuals' and entities' effectiveness in performance of such agreements or contracts.

"(2) BONUSES.—Notwithstanding any other provision of law, but subject to subparagraph (B)(ii), the Secretary may make bonus payments under the program from the Federal Health Insurance Trust Fund and the Federal

Supplementary Medical Insurance Trust Fund in amounts that do not exceed the amounts authorized under the program in accordance with the following:

"(A) PAYMENTS TO PROGRAM ADMINISTRATORS.—The Secretary may make bonus payments under the program to program administrators.

"(B) PAYMENTS TO ENTITIES FURNISHING SERVICES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make bonus payments to individuals or entities furnishing items or services for which payment may be made under the program, or may authorize the program administrator to make such bonus payments in accordance with such guidelines as the Secretary shall establish and subject to the Secretary's approval.

"(ii) LIMITATIONS.—The Secretary may condition such payments on the achievement of such standards related to efficiency, improvement in processes or outcomes of care, or such other factors as the Secretary determines to be appropriate.

"(3) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the program, or with an entity to administer the program, unless such entity guarantees that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

"(d) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to the demonstration program shall not be subject to review by a judicial or administrative tribunal:

"(1) Limiting the implementation of the program under subsection (a)(2).

"(2) Establishment of program participation standards under subsection (a)(5) or the denial or termination of, or refusal to renew, an agreement with an entity to provide health care items and services under the program.

"(3) Establishment of program administration contract performance standards under subsection (b)(6), the refusal to renew a program administration contract, or the noncompetitive award or renewal of a program administration contract under subsection (b)(4)(B).

"(5) Establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract.

"(6) A determination with respect to the program (where specifically authorized by the program authority or by subsection (c)(2))—

"(A) as to whether cost savings have been achieved, and the amount of savings; or

"(B) as to whether, to whom, and in what amounts bonuses will be paid.

"(e) APPLICATION LIMITED TO PARTS A AND B.—None of the provisions of this section or of the demonstration program shall apply to the programs under part C.

"(f) REPORTS TO CONGRESS.—Not later than two years after the date of enactment of this section, and biennially thereafter for six years, the Secretary shall report to the Congress on the use of authorities under the demonstration program. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under this title.".

TITLE III—MEDICARE+CHOICE PROGRAM STABILIZATION AND IMPROVEMENTS

Subtitle A—Payment Reforms

SEC. 301. INCREASE IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE IN 2001 AND 2002.

Section 1853(c)(6)(B) (42 U.S.C. 1395w–23(c)(6)(B)) is amended—

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0 percentage points''.

SEC. 302. PERMANENTLY REMOVING APPLICATION OF BUDGET NEUTRALITY BEGINNING IN 2002.

Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), in the matter following clause (ii), by inserting ''(for years before 2002)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(before 2002)'' after ''for each year''.

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

(a) IN GENERAL.—Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is amended—

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

(2) by adding at the end the following new subclause:

''(II) For 2002 for any of the 50 States and the District of Columbia, $450.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to years beginning with 2002.

SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND IN 2002.

Section 1853(c)(2) (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

"except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.".

SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

(a) IN GENERAL.—Section 1853(c)(1)(C)(ii) (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking "(ii) For a subsequent year" and inserting "(ii)(I) Subject to subclause (II), for a subsequent year"; and

(2) by adding at the end the following new subclause:

"(II) During 2002, 2003, 2004, and 2005, in the case of a Medicare+Choice payment area in which there is no more than one contract entered into under this part as of July 1 before the beginning of the year, 102.5 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.".

(b) CONSTRUCTION.—The amendments made by subsection (a) do not affect the payment of a first time bonus under section 1853(i) of the Social Security Act (42 U.S.C. 1395w–23(i)).

SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN CERTAIN MEDICARE+CHOICE PAYMENT AREAS BELOW NATIONAL AVERAGE.

Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(1) in the matter before subparagraph (A), by striking "or (C)" and inserting "(C), or (D)"; and

(2) by adding at the end the following new subparagraph:

"(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

"(i) IN GENERAL.—For each year beginning with 2004, in the case of a Medicare+Choice payment area for which the Medicare+Choice capitation rate under this paragraph would otherwise be less than the United States per capita cost (USPCC), as calculated by the Secretary, a Medicare+Choice organization may negotiate with the Medicare Benefits Administrator an annual per capita rate that—

"(I) reflects an annual rate of increase up to the rate of increase specified in clause (ii);

"(II) takes into account audited current data supplied by the organization on its adjusted community rate (as defined in section 1854(f)(3)); and

"(III) does not exceed the United States per capita cost, as projected by the Secretary for the year involved.

"(ii) MAXIMUM RATE DESCRIBED.—The rate of increase specified in this clause for a year is the rate of inflation in private health insurance for the year involved, as projected by the Medicare Benefits Administrator, and includes such adjustments as may be necessary—

"(I) to reflect the demographic characteristics in the population under this title; and

"(II) to eliminate the costs of prescription drugs.

"(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.".

SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED ON DATA FROM ALL SETTINGS.

Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

"and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the methodology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.".

SEC. 308. DELAY FROM JULY TO OCTOBER, 2000 IN DEADLINE FOR OFFERING AND WITHDRAWING MEDICARE+CHOICE PLANS FOR 2001.

Notwithstanding any other provision of law, the deadline for a Medicare+Choice organization to withdraw the offering of a Medicare+Choice plan under part C of title XVIII of the Social Security Act (or otherwise to submit information required for the offering of such a plan) for 2001 is delayed from July 1, 2000, to October 1, 2000, and any such organization that provided notice of withdrawal of such a plan during 2000 before the date of the enactment of this Act may rescind such withdrawal at any time before October 1, 2000.

Subtitle B—Administrative Reforms

SEC. 311. PERMITTING MEDICARE+CHOICE BENEFICIARIES TO RETURN TO NURSING HOME FOR RECEIPT OF COVERED SKILLED NURSING FACILITY SERVICES.

(a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

"(l) PERMITTING RETURN TO CERTAIN SKILLED NURSING FACILITIES FOR THE RECEIPT OF COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

"(1) IN GENERAL.—A Medicare+Choice plan must provide coverage of post-hospital extended care services

through a home skilled nursing facility described in paragraph (2) and consistent with paragraph (3) if the enrollee elects to receive such coverage through such facility and the facility—

"(A) has a contract with the Medicare+Choice organization for the provision of such services; or

"(B) agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

The organization shall provide payment to the home skilled nursing facility consistent with the contract described in subparagraph (A) or the agreement described in subparagraph (B), as the case may be.

"(2) HOME SKILLED NURSING FACILITY.—For purposes of this subsection, a home skilled nursing facility described in this paragraph, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, is any of the following skilled nursing facilities:

"(A) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

"(B) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in paragraph (5)) which provided residence to the enrollee at the time of such admission.

"(C) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

"(3) NO LESS FAVORABLE TERMS AND CONDITIONS OF COVERAGE.—The coverage provided under this subsection (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

"(4) CONSTRUCTION.—Nothing in this subsection shall be construed—

"(A) as requiring coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan; and

"(B) as preventing a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

"(5) CONTINUING CARE RETIREMENT COMMUNITY DEFINED.—For purposes of this subsection, the term 'continuing care retirement community' means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act.

TITLE IV—MEDICARE PART A AND B PROVISIONS

SEC. 401. 1-YEAR DELAY IN 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

(1) by redesignating subparagraph (II) as subparagraph (III);

(2) by inserting in subparagraph (III), as redesignated, ''24 months'' following ''periods beginning''; and

(3) by inserting after subclause (I) the following new subclause:

''(II) For the 12-month period beginning after the period described in subclause (I), such amount (or amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).''.

SEC. 402. ADVISORY OPINIONS.

(a) MAKING PERMANENT EXISTING ADVISORY OPINION AUTHORITY.—Section 1128D(b)(6) (42 U.S.C. 1320a–7d(b)(6)) is amended by striking ''and before the date which is 4 years after such date of enactment''.

(b) NONDISCLOSURE OF REQUESTS AND SUPPORTING MATERIALS.—

(1) IN GENERAL.—Section 1128D(b) (42 U.S.C. 1320a–7d(b)) is amended by adding at the end the following new paragraph:

''(7) NONDISCLOSURE OF REQUESTS AND SUPPORTING MATERIALS.—A request for an advisory opinion under this subsection and any supporting written materials submitted by the party requesting the opinion shall not be subject to disclosure under section 552 of title 5, United States Code.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to requests made before, on, or after the date of the enactment of this Act.

TITLE V—MEDICAID

SEC. 501. DSH PAYMENTS.

(a) CONTINUATION OF MEDICAID DSH ALLOTMENTS AT FISCAL YEAR 2000 LEVELS FOR FISCAL YEARS 2001 AND 2002.—Section 1923(f) (42 U.S.C. 1396r-4(f)), as amended by section 601 of the Medicare, Medicaid, and SCHIP Balanced

Budget Refinement Act of 1999 (as enacted into law by section 1000(a)(6) of Public Law 106–113), is amended—

(1) in paragraph (2)—

(A) in the matter preceding the table, by striking ''2002'' and inserting ''2000'';

(B) in the table in such paragraph, by striking the columns labeled ''FY 01'' and ''FY 02'' relating to fiscal years 2001 and 2002; and

(2) in paragraph (3)—

(A) by striking ''2003'' in the heading and inserting ''2001''; and

(B) by striking ''2003'' and inserting ''2001''.

(b) ASSURING IDENTIFICATION OF MEDICAID MANAGED CARE PATIENTS.—

(1) IN GENERAL.—Section 1932 (42 U.S.C. 1396u–2) is amended by adding at the end the following:

''(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

''(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or

''(2) to include a sponsorship code in the identification card issued to individuals covered under this title in order that a hospital may identify a patient as being entitled to benefits under this title.''.

(2) CLARIFICATION OF COUNTING MANAGED CARE MEDICAID PATIENTS.—Section 1923(a)(2)(D) (42 U.S.C. 1396r–4(a)(2)(D)) is amended—

(A) in subsection (a)(2)(D), by inserting after ''the proportion of low-income and medicaid patients'' the following: ''(including such patients who receive benefits through a managed care entity)'';

(B) in subsection (b)(2), by inserting after ''a State plan approved under this title in a period'' the

following: ''(regardless of whether they receive benefits on a fee-for-service basis or through a managed care entity)''; and

(C) in subsection (b)(3)(A)(i), by inserting after ''under a State plan under this title'' the following: ''(regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) apply to payments made for periods on or after January 1, 2001.

SEC. 502. NEW PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (13)—

(A) in subparagraph (A), by adding ''and'' at the end;

(B) in subparagraph (B), by striking ''and'' at the end; and

(C) by striking subparagraph (C); and

(2) by inserting after paragraph (14) the following new paragraph:

''(15) for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (aa);''.

(b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

''(aa) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Beginning with fiscal year 2001 and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health

center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

"(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of the center or clinic of furnishing such services during fiscal year 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase in the scope of such services furnished by the center or clinic during fiscal year 2001.

"(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

"(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

"(B) adjusted to take into account any increase in the scope of such services furnished by the center or clinic during that fiscal year.

"(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or

services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year in accordance with the regulations and methodology referred to in paragraph (2). For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

''(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic (at least quarterly) by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

''(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

''(A) is agreed to by the State and the center or clinic; and

''(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 4712 of the Balanced Budget Act of 1997 (Public Law 105-33; 111 Stat. 508) is amended by striking subsection (c).

(2) Section 1915(b) (42 U.S.C. 1396n(b)) is amended by striking ''1902(a)(13)(E)'' and inserting ''1902(a)(15), 1902(aa),''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2000, and apply to services furnished on or after such date.

SEC. 503. ADDITIONAL ENTITIES QUALIFIED TO DETERMINE MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL.—Section 1920A(b)(3)(A)(i) (42 U.S.C. 1396r–1a(b)(3)(A)(i)) is amended—

(1) by striking ''or (II)'' and inserting '', (II)''; and

(2) by inserting ''eligibility of a child for medical assistance under the State plan under this title, or eligibility of a child for child health assistance under the program funded under title XXI, (III) is an elementary school or secondary school, as such terms are defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801), an elementary or secondary school operated or supported by the Bureau of Indian Affairs, a State child support enforcement agency, a child care resource and referral agency, an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act, or a State office or entity involved in enrollment in the program under this title, under part A of title IV, under title XXI, or that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), or (IV) any other entity the State so deems, as approved by the Secretary'' before the semicolon.

(b) TECHNICAL AMENDMENTS.—Section 1920A (42 U.S.C. 1396r-1a) is amended—

(1) in subsection (b)(3)(A)(ii), by striking ''paragraph (1)(A)'' and inserting ''paragraph (2)(A)''; and

(2) in subsection (c)(2), in the matter preceding subparagraph (A), by striking ''subsection (b)(1)(A)'' and inserting ''subsection (b)(2)(A)''.

(c) APPLICATION TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) (42 U.S.C. 1396r-1(b)) is amended by adding at the end after and below paragraph (2) the following flush sentence:

''The term 'qualified provider' includes a qualified entity as defined in section 1920A(b)(3).''.

(d) APPLICATION UNDER TITLE XXI.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following new subparagraph:

''(D) Section 1920A (relating to presumptive eligibility).''.

SEC. 504. 1-YEAR EXTENSION OF WELFARE-TO-WORK TRANSITION UNDER THE MEDICAID PROGRAM.

Section 1925(f) (42 U.S.C. 1396r–6(f)) is amended by striking ''2001'' and inserting ''2002''.

SEC. 505. MEDICAID COUNTY-ORGANIZED HEALTH SYSTEMS.

Section 9517(c)(3)(C) of the Comprehensive Omnibus Budget Reconciliation Act of 1985 is amended by striking ''10 percent'' and inserting ''14 percent''.